SUMMARY OF BENEFITS AND COVERAGE (SBC) FREQUENTLY ASKED QUESTIONS

Updated May 2013

General Information

Q1*. What is a Summary of Benefits and Coverage?*

A1. A Summary of Benefits and Coverage (SBC) is four-page (double-sided) communication required by the federal government. It must contain specific information, in a specific order and with a minimum size type, about a group health benefit's coverage and limitations.

Q2. *Who must provide an SBC?*

A2. For fully insured plans, the insurer is responsible for providing the SBC to the plan administrator (usually this is the employer). The plan administrator and the insurer are both responsible for providing the SBC to participants, although only one of them actually has to do this.

For self-funded plans, the plan administrator is responsible for providing the SBC to participants. Assistance may be available from the plan administrator's TPA, advisor, etc., but the plan administrator is ultimately responsible. (The plan administrator is generally the employer, not the claims administrator.)

Q3. *When is an SBC required?*

A3. Starting with the first plan year that begins on or after Sept. 23, 2012, an SBC is required whenever application or open enrollment materials are provided to new hires or current employees. If no application or open enrollment materials are given, an SBC must be provided when the person can first enroll.

Q4. Are any plans exempt from this requirement?

A4. No. This requirement applies to all employers – private, government, and not-for-profit, fully insured and self-funded, grandfathered and non-grandfathered. There is no minimum employer size to have this

obligation.

However, there is a delayed effective date for closed blocks of insured business. An SBC does not need to be provided until Sept. 23, 2014 if:

- The insured product is no longer being actively marketed;
- The health insurer stopped actively marketing the product prior to September 23, 2012; and
- The health insurer has never provided an SBC with respect to the insured product.

In addition, expatriate plans do not have to provide SBCs until the 2015 plan year. (An expatriate plan is one designed to cover employees who are living overseas.)

Q5. *What types of plans must provide SBCs?*

A5. All group health plans must provide SBCs unless they are specifically exempted. Exempted plans include:

- Standalone dental and vision
- Health FSAs unless the employer makes significant contributions (see Q&A 15 for details)
- Retiree only plans
- Medicare supplement
- Hospital indemnity and specified diseases
- Long-term care
- Accident and disability

Q6. *Are SBCs needed for wellness programs, EAPs and HRAs?*

A6. In certain circumstances, yes. See Q&As 11 – 13.

Completing the SBC

Q7. *What information must be included in an SBC?*

A7. An SBC must contain:

- Uniform definitions of standard insurance terms and medical terms (provided in the glossary)
- A description of the coverage for certain categories of benefits
- The exceptions, reductions, and limitations of the coverage
- The cost-sharing provisions of the coverage (deductible, coinsurance, and copayment obligations)
- A statement as to whether the plan offers minimum essential and minimum value coverage (added for 2014)
- The renewability and continuation of coverage provisions
- Coverage examples
- A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage
- Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and

- an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance)
- For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers
- For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage
- An Internet address for obtaining the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

IMPORTANT: The agencies have issued **very specific** instructions on how to complete the SBC. If you are completing an SBC, you need to read and follow the instructions. The instructions are here: http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf

A blank SBC to use with 2013 plan years is here: http://www.dol.gov/ebsa/correctedsbctemplate.doc.

A blank SBC to use with 2014 plan years is here: http://www.dol.gov/ebsa/correctedsbctemplate2.doc

A sample completed SBC for 2013 is here: http://www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf

A sample completed SBC for 2014 is here: http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC2.pdf

Since these instructions were issued, the DOL has made a few liberalizations. They are:

- If a plan's terms deviate significantly from the template or instructions, you may modify the template/entries to the extent needed to be accurate
- You only need to include the footer on the first and last page and the header only needs to be on the first page
    - When completing the header, either the company name, any insurer name or the plan name can be listed first
- If there are multiple plan options, list the name commonly used; if there is no common name, a generic name is fine

In addition, for 2014 employers and carriers may address the prohibition on annual dollar limits for essential health benefits by either:

- Deleting the row that asks about annual limits; or
- Completing the annual limits question with "no" and stating in the "Why It Matters" column: "The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits."

Q8. *What changes have been made to the SBC for 2014?*

A.8. There are very few changes for 2014. The SBC must now state (on page 4) whether or not the plan provides "minimum essential" coverage and whether or not the plan provides "minimum value" coverage. (However, if an employer or carrier has already begun preparing its 2014 SBC and including this information on page 4 would be difficult, the needed information can be included in an attachment or cover letter.) The supplemental information must say:

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/does not] provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides**.

There are no changes to the examples (including costs) that must be completed in the SBC, to the glossary that must accompany the SBC or to the SBC calculator.

Q9. *Do I need a separate SBC for each benefit option?*

A9. You do not need a separate SBC for each benefit option as long as you can illustrate multiple options clearly. So, for example, you can show multiple coverage tiers and deductible/coinsurance/ copay options on one SBC if the balance of the coverage is very similar. If you prefer to create a separate SBC for each tier, PPO option, etc., that is fine, too.

Q10. *How do I handle dental benefits?*

A10. Stand-alone dental benefits (those that are elected separately from medical and have a separate premium) do not need an SBC. You would list "Dental Care (Adult)" as a "Service Your Plan Does Not Cover" since it is not covered under the medical plan that the SBC is describing.

Integrated dental benefits (those that are elected as part of medical and do not have a separate premium) would be listed as "Dental Care (Adult)" under "Other Covered Services," with no additional detail given.

Note: Non-grandfathered plans must cover routine pediatric dental care. It is unclear how grandfathered plans should address non-covered pediatric care in the SBC, but in the interest of accuracy simply stating "Dental Care" as a "Service Your Plan Does Not Cover" would seem to be preferable if dental care for children is not covered under the medical plan.

Q11. *How do I handle vision benefits?*

A11. Stand-alone vision benefits (those that are elected separately from medical and have a separate premium) do not need an SBC. You would list "Routine eye care (Adult") as a "Service Your Plan Does Not Cover" since it is not covered under the medical plan that the SBC is describing.

Integrated vision benefits (those that are elected as part of medical and do not have a separate premium) would be listed as "Routine eye care (Adult)" under "Other Covered Services," with no additional detail given.

Note: Non-grandfathered plans must cover routine pediatric vision care. It is unclear how grandfathered plans should address non-covered pediatric care in the SBC but in the interest of accuracy simply stating

"Routine eye care" as a "Service Your Plan Does Not Cover" would seem to be preferable if vision care for children is not covered under the medical plan.

Q12. *How do I handle an HRA?*

A12. A standalone HRA will need an SBC. The employer should complete the SBC to reflect the HRA's coverage (which means that many sections will be completed as "not applicable").

If the HRA is integrated with the medical plan, you may include the amount of the employer contributions to the HRA to the extent they are available to reduce deductibles, etc. and explain the HRA contribution is available for cost sharing.

Q13. *How do I handle an EAP?*

A13. If the EAP is a group health plan it will need an SBC. It may be possible to note those services on the medical SBC (see the sample Coverage Example for diabetes created by the agencies for a possible approach); if the services are too complex, the employer should complete the SBC to reflect the EAP's coverage (which means that many sections will be completed as "not applicable").

Note: Because of the variety of services provided by EAPs, it is not possible to say whether all EAPs are or are not "group health plans." In general, the more medical care that is provided by the EAP, the likelier it is that the EAP is a group health plan. So, for example, an EAP that only provides education or referrals would not be a group health plan. An EAP that provides direct counseling probably is a group health plan.

Q14. *How do I handle a wellness program?*

A14. A wellness program that is a group health plan will need to provide an SBC. It may be possible to note those services and/or incentives on the medical SBC (see the sample Coverage Example for diabetes created by the agencies for a possible approach); if the services are too complex, the employer should complete the SBC to reflect the wellness program's coverage (which means that many sections will be completed as "not applicable").

Note: Because of the variety of approaches taken by wellness programs, it is not possible to say whether all wellness programs are or are not "group health plans." If the incentives provided by the program are not related to the health plan, the wellness program is not a group health plan. So, for example, if the reward for completing a health risk assessment is a gift card, the program is not a group health plan and no SBC is needed. If the wellness program provides medical care (e.g., special services for diabetics) it is likely that the wellness program is a group health plan.

Q15. *How do I handle an HSA?*

A15. HSAs are not considered "group health plans" and do not need an SBC (although the underlying high deductible health plan will need one). Employers may include the amount of any employer contribution to an HSA to the extent they are available to reduce deductibles, etc. and explain the HSA contribution is available for cost sharing.

Q16. *How do I handle a FSA?*

A16. An SBC is not needed for a FSA unless the employer makes significant contributions (over $500/year/participant or more than twice the participant's contribution). If an employer makes any health FSA contributions, it may include the amount of any employer contribution to the health FSA to the extent they are available to reduce deductibles, etc. and explain the FSA contribution is available for cost sharing.

Q17. *How do I handle carve-out benefits (such as prescription drug or behavioral health)?*

A17. Through at least 2014, fully insured plans have several options:

- They can arrange with one insurer to include the information from the other insurer
- They can combine the two into a single SBC themselves
- They can provide each SBC, with a note advising participants that coverage is provided by more than one carrier, the SBCs should be read together, and the plan administrator can be contacted for help with understanding how the coverages work together; plan administrator contact information must be provided.

Self-funded plans will need to do their best to combine the multiple coverages into a single SBC.

Q18. *Do I need to include information on premiums/contributions?*

A18. Premium and contribution information is not required.

Q19. *Can I include information on premiums/contributions?*

A19. Yes, but it must be provided at the end of the SBC.

Q2. *If the plan is grandfathered, do I need to state this?*

A20. No, this disclosure is not needed on the SBC. If you wish to include a statement that the plan is grandfathered you can, but it must be at the end of the SBC.

Q21*. Can I simply reference the SPD in the SBC?*

A21. You cannot substitute a reference to the SPD for any required information. You can create a footnote advising the reader to consult the SPD or certificate for more information, including a reference to particular page numbers for more information about a specific item.

Q22. *Can I change the format or order of the SBC?*

A22. Generally, no. You can widen columns.

Q23. *Can I reword the "Why It Matters" responses?*

A23. No.

Q24. *Must the SBC be in color?*

A24. No, it can be in color or grayscale.

Q25. *Why is this so inflexible?*

A25. The purpose of the SBC is to make it easier for employees to compare coverage options. The regulatory agencies believe that consistent presentation will make it easier for employees to do side-by-side comparisons.

Q26. *How often do I need to update the SBC?*

A26. You only need to update the SBC at renewal/open enrollment unless you make a material change during the year. In that case, at least 60 days **before** the effective date of the change, you must either distribute an updated SBC or provide written notice of the change. Distributing the revised SBC or notice will qualify as an SMM.

Q27. *What's a material change?*

A27. A material change is something addressed in the SBC that the average participant would consider important, like a change in deductible, coverage for a new benefit or a whole new network. It can be an increase in benefits or a reduction. Regulatory changes normally will not be considered a material change that would require a mid-year notice or reissuance of the SBC.

Completing the Coverage Examples

Q28. *How do I prepare the coverage examples?*

A28. The coverage examples are based on information provided by the regulatory agencies regarding the projected dates of service and the anticipated cost of certain prescribed services (maternity and care of diabetes; the cost of services in the examples are the same for 2013 and 2014). The plan's actual cost sharing (deductible, co-pays and coinsurance) and any applicable exclusions or limits should be used to illustrate the "Patient pays" entries.

Q29. *If I illustrate several benefit options in one SBC, what do I base the comparison on?*

A29. You should illustrate self-only coverage and clearly state on the SBC that self-only coverage is being illustrated.

Q30. *Has the government provided any assistance with these calculations?*

A30. HHS/CMS has posted a calculator that can be used by employers to complete the comparison. Employers are **not** required to use this calculator.

The calculator and instructions are available at:

http://cciio.cms.gov/resources/files/sbc-coverage-calculator-20120723.xlsm

http://cciio.cms.gov/resources/files/sbc-cover-ex-calc-instructions.pdf

http://cciio.cms.gov/resources/files/sbc-cover-ex-calc-check.pdf

Q31. *The costs we are supposed to use in the examples are much more (or less) than we typically see. Can/should I use my plan's data?*

A31. No. **Employers must use the HHS-supplied costs, even though they may not reflect their plan's experience.** (The idea is that if costs in the examples are uniform, employees will be better able to understand how cost sharing will work under the options they are considering.)

Q32. *I am worried that my employees will think the amounts shown in the examples are what the plan and they will pay if they actually have a baby or are treated for diabetes.*

A32. The Coverage Examples sheet states in large print that it is not a cost estimator, and test groups apparently understood this. In any event, the agencies have considered the issue and believe this approach is best.

Providing the Glossary

Q33. *What is the glossary?*

A33. The glossary is a required, standard glossary of 44 terms frequently used with group health plans.

Q34. *Can I alter it to better fit my situation?*

A34. No. If there is a significant difference between the plan's and the glossary's terms, you can address this on the SBC (presumably through a footnote). To reduce participant confusion, it may make sense to revise your plan's terminology to match the glossary terminology, when possible.

Q35. *Must I provide copies of the glossary with the SBC?*

A35. No, but you must:

- Tell participants at the bottom of the first page of the SBC where the glossary is posted (it can be on the employer's website, the insurer's website, or an agency website). The government version is posted at:
  http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf
- Mail a paper copy within seven business days after receiving a request for a paper glossary

Distributing the SBC

Q36. *Who is responsible for providing an SBC?*

A36. The insurer is responsible for providing an SBC to the employer within seven days after the employer completes an application. The insurer and the plan administrator are each responsible for providing the SBC to participants, but only one of them needs to actually do it – they need to work out who will do the distribution. For self-funded plans, the plan administrator is responsible for providing the SBC. The plan administrator can hire others, like its TPA, to help, but the plan administrator is ultimately responsible.

Q37. *Who must receive an SBC, and when?*

A37. SBCs must be provided:

- At open enrollment
  - The SBC must be included with the open enrollment materials
  - Only the SBC for the option the employee is currently enrolled in must be provided (if you would rather provide all SBCs instead, you may)
  - If the employee asks for the SBC for other options, those SBCs must be provided within seven business days
  - SBCs must be provided to current employees, retirees (unless they are enrolled in a retiree-only plan) and COBRA beneficiaries
- At renewal if there is no open enrollment
  - If the prior year's election simply carries over, the SBC for the employee's current coverage must be provided at least 30 days before the new plan or policy year. (If the plan or policy has not been reissued or renewed by then, the SBC is due as soon as possible after renewal/reissue, and in no event later than seven business days after either the new policy is issued or a written confirmation of an intent to renew is received.)

    - If the employee asks for the SBC for other options, those SBCs must be provided within seven business days
    - SBCs must be provided to current employees, retirees (unless they are enrolled in a retiree-only plan) and COBRA beneficiaries
- At initial enrollment
    - The SBC for all options the employee may choose among must be provided with the enrollment materials
    - If no enrollment materials are provided, the SBC for all options must be provided by the first day the new employee may enroll
- At special enrollment
    - The SBC for the option the individual is enrolled in must be provided within 90 calendar days after enrollment as a special enrollee
    - The SBC must be provided within seven business days after a request for the SBC, if sooner

Q38. *What does "within seven business days" mean?*

A38. The SBC must be postmarked, faxed or emailed by the close of the seventh business day after the request is received. (A request for a paper copy must be mailed or faxed. If a request for an SBC is made electronically, the SBC can be provided electronically, with the usual statement that free paper copies can be requested.)

Q39. *Do I need to provide an SBC to covered family members?*

A39. A separate SBC does not need to be provided to covered family members unless you are aware that a family member lives at another address. In that case the person living away needs their own SBC.

Q40. *Can I include the SBC in my SPD?*

A40. You may include the SBC in the SPD as long as:

- It is prominently displayed -- e.g., right after the table of contents or introduction; and
- The entire SBC is inserted, without adding any material between its pages or sections or deleting any part of the SBC

Q41. *Can I provide the SBC electronically?*

A41. It depends on the situation:

- If enrollment is exclusively online, the SBC can be provided online
- If enrollment is not exclusively online, there are different rules for new enrollees and current participants
    - For new enrollees:
        - The SBC must be reasonably accessible (e.g., posted on the employer's intranet or website)
        - The employee must be notified that the SBC is available, where it is located (with the internet address or a link) and that a paper copy is available at no cost, with contact information to request a paper copy
    - For enrolled employees:
        - If the employee regularly uses a computer as part of his job the SBC or notice of

where the SBC is posted must be sent to the computer the employee regularly uses, with an explanation of the significance of the SBC and that a paper copy is available at no cost with contact information to request a copy
    - If the employee does not regularly use a computer as part of his job, the SBC may not be provided electronically
- For enrolled retirees, COBRA participants and special enrollees who do not live with the employee:
    - The person must provide consent to email the SBC/plan materials and provide his email address
    - If the person does not provide the consent and email address, the SBC may not be provided electronically

Q42. *Is there sample notification language?*

A42. Yes. The agencies have provided sample language (which you may, but are not required to, use).

> **Availability of Summary Health Information**
>
> As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
>
> Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
>
> The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

Q43. *How may I provide notice that the SBC is available electronically?*

A43. The notice that the SBC is available electronically can be mailed (many employers send a postcard) or emailed (with a "return receipt" feature).

Q44. *If I provide SBCs electronically can I display the SBC on a single web page with scrolling features, allow sorting by feature, and/or widen columns?*

A44. Yes, as long as a paper version with the pages set up as required is available. Columns and rows may not be deleted unless the agencies specifically allow this (as they have done with deleting the annual limits row in 2014).

Other Languages

Q45. *Are there requirements to provide the SBC in languages other than English?*

A45. Yes. Similar to the requirement to provide SPDs in languages other than English in certain situations, the SBC must be provided in Chinese, Navajo, Spanish and Tagalog if issued in counties where more than 10 percent of the population is literate only in one of these languages.

The English version of the SBC distributed in those counties must disclose the availability of language services on the page of the SBC that includes the "Your Rights to Continue Coverage" and "Your

Grievance and Appeals Rights" sections. The Department of Labor has provided this sample language:

SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

Q46. *Can I include the information about language assistance services even if the SBC is not being provided in a county that meets the non-English threshold?*

A46. Yes.

Q47. *How can I determine if I have employees in a county that needs a translated version?*

A47. The Department of Health and Human Services has posted a list of the counties that meet the 10 percent threshold at http://www.cciio.cms.gov/resources/factsheets/clas-data.html

Q48. *Are translated versions of the SBC and glossary available?*

A48. Yes. You can access them at http://cciio.cms.gov/resources/other/index.html#sbcug

Other Disclosure Requirement and Penalties

Q49. *Does this replace my SPD, certificate or any summary I usually provide at open enrollment?*

A49. No, the SBC does not replace your SPD or certificate. If you already provide a summary of benefits, you can continue to provide it and also provide the SBC, but you cannot provide anything instead of the SBC.

Q50. *My state also has disclosure requirements. Must I follow them, too?*

A50. If a state imposes additional requirements, those requirements also must be met (possibly in a separate document due to the strict formatting rules that apply to SBCs).

Q51. *What happens if I don't provide an SBC?*

A51. The penalties for willful (i.e., deliberate) failure to provide an SBC are up to $1,000 for each person who should have received the SBC and did not. The penalty for negligent failure to provide is up to $100 per day for each person who should have received the SBC and did not.

The regulatory agencies have said they will work with employers who have made good faith efforts to comply but didn't quite get it right.

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